

EMS ADVISORY COUNCIL MEETING

MINUTES

October 17, 2013

Rough Ride Room State Capitol

Members Present: Terry Ault, Liz Beck (via telephone for her portion of meeting), Lynette Dickson, Curt Halmrast, Lynn Hartman, June Herman, Tim Meyer, Ken Reed, Jeff Sather, Diane Witteman.

Members Not Present: Kari Enget, Marlene Miller.

DoH Representation Present: Tom Nehring, Jan Franklund, Amanda Roehrich, Lindsey Narloch, Elizabeth Pihlaja, Kari Kuhn.

Others Present: Neil Frame, Mona Thompson, Adam Parker (Sanford AirMed), Jim DeMell.

Tim Meyer welcomed the committee and introductions were made around the table.

We welcome Elizabeth Pihlaja who joins the council as the new EMSC Coordinator with the Division of EMS and Trauma.

Approval of Minutes:

Motion made to approve the minutes from June, 2013 meeting.

Motion made by Curt H., seconded by Diane W.

No further discussion; motion carried.

Health Information Network

Neil Frame described the Health Information Network as the process of putting together a common depository for the nation's health information to have access and true time information to better patient care. Neil has been on the committee for about a year representing EMS to ensure their needs and processes are addressed.

Points of discussion:

- Viable option for EMS?
- Electronic submission will have to be mandated
- What should the role of EMSAC be in this process
- Lynette Dickson serves as the chair on the committee and is supportive of EMSAC being the driver for EMS
- As EMS gets more publicly involved (community paramedics) the benefit will be more apparent
- There's a long way to go and the price for a new electronic submission system is high.
- The state needs to do a better job of education as EMS is not aware of the capabilities of the current system.
- Can there be a possible future financial incentive to EMS for joining in the system
- First step to create a consistent message to take to EMS services
- Form a subcommittee: Lynette Dickson, Lindsey Narloch (chair), Neil Frame, Diane Witteman, Elizabeth Pihlaja.
- Curt will be supplying Lindsey a name of somebody giving some push back and Lindsey will set up a meeting.
- Funding for a new database system was submitted as an alternative allocation package during the legislative session and was rejected.

EMSAC Role in QI Process Subcommittee Progress

At the June EMSAC meeting it was decided to establish a subcommittee to work on this:

Dr. Sather (chair), Kathy Lonski, Kari Enget, Tom Nehring and Ruth Hursman.

A report is to be brought to the next meeting.

Establishing Strategic Planning Subcommittee

This subcommittee was discussed at the June meeting.

“The state department of health shall establish and update biennially a plan for integrated emergency medical services in this state. The plan must identify ambulance operations areas, emergency medical services funding areas that require state financial assistance to operate a minimally reasonable level of emergency medical services, and a minimum reasonable cost for an emergency medical services operation.” NDCC Chapter 23-46 created from the passing of HB 1044. <http://www.legis.nd.gov/cencode/t23c46.pdf?20131105081129>

The committee will meet and decide from there if other members / input are needed.

Tom Nehring (Chair), Ken Reed, June Herman, Curt Halmrast, Mona Thompson, Tim Meyer.

This committee should plan to meet face to face in November and monthly thereafter via teleconference / BTWAN.

Rules discussion

- Discussion regarding pushback from I85s in ND.
 - There was a choice not to do a bridge course in ND
 - I85s must do a complete AEMT course or transition to an EMT
- AFAA requirements are being changed to meet those of an EMT as they are treated as an equal level provider
- EVOC
 - Currently:
 - EVOC required once by each EMS agency member
 - New members required to have EVOC training within one year of joining the agency
 - Waivers may be granted to allow courses to be completed without the driving portion
 - Language has been changed to require an EVOC course rather than the specific DOT course
 - DEMST is considering making this a responsibility of the individual services
 - Standards and accountability need to be retained
 - If there's no requirement it will not happen
 - How standardize and certify for validity
 - How to regulate instructors
 - Onus could be put on the instructors as with CPR
 - Insurance requirements
 - Proof of benefit

Motion made to accept changes as presented.

Motion made by Dr Sather, seconded by Ken R.

Motion to be revisited with other information brought forward at next EMSAC meeting.

No further discussion; motion carried.

- 33-36-01-03
- **EMR (a)** Any reference to DOT curriculum will be removed.

Motion made to change to state that curriculum must be approved by the Department. This change will be made at each primary licensure level.

Motion made by Diane W., seconded by Lynn H.

No further discussion; motion carried.
- **EMR (g)** This should coincide with what is required by NREMT and any language referencing a number of hours will be removed.

Motion to accept the proposed changes regarding recertification at each licensure level.

Motion made by Lynn H., seconded by June H.

No further discussion; motion carried.

- **EMT (g)** After discussion it was decided that the listing of physical requirements is not necessary and will be removed at each licensure level (including the previously discussed EMR level). The NREMT has standards that have stood the test of civil suit.

Motion to accept the changes as proposed by the Health Department.

Motion made by Diane W., seconded by Ken R.

No further discussion; motion carried.

- **State Certified EMT.**

- Change 'certified' to 'licensed throughout this section.
- Purpose of section is to only maintain State EMT for those between 16 – 18 years of age.
- Cannot be NREMT certified until 18.

Motion to change the listed date for conversion from State EMT to NREMT EMT if over the age of 18 to June 30, 2017 for consistency.

Motion made by June H., seconded by Terry A.

No further discussion; motion carried.

Discussion regarding out of state EMTs working in ND and whether or not they need to become NREMT certified.

Motion made that for DEMST to re-work this section to convey the appropriate message regarding state EMTs over and under the age of 18.

Motion made by June H., seconded by Curt H.

No further discussion; motion carried.

- **EMT –I (h)**

- EMT-I must be maintained in rule until 2017.
- This section applies to those already certified as EMT-I/85.
- Change 'obtain medical direction' to 'obtain medical director'.
- Remove the physical requirements as discussed earlier.
- Change 'Persons obtaining national registry certification' to 'Persons holding national registry certification'.

Motion to accept changes as written with changes outlined above.

Motion made by Ken R., seconded by Dr Sather.

No further discussion; motion carried.

- The American College of Emergency Physicians has a policy stating that all medical direction for EMS must be by emergency medicine doctors.
- The verbiage will be reviewed and checked for redundancy in reference to 50-03-03.
- AEMT, EMT-I/99 and Paramedic – changes will be made as referred to all sections above.
- AFAA – Housekeeping changes.

- **Continuing Education**

Motion to accept changes as proposed by the Department.

Motion made by Lynn H., seconded by Curt H.

No further discussion; motion carried.

- **EMS Instructor. (e, 1)** Change to reflect 'or' rather than all inclusive. Curriculum must be approved by the department as council members stated there is no longer a DOT curriculum.

Motion to approve changes proposed by the Department as well as the change listed above.

Motion made by Dian W, seconded by Lynette D.

No further discussion; motion carried.

- **AEMT's.**

Motion made to include current and subsequent licensed AEMT's in the NREMT Pilot Project.

Motion made by Ken R., seconded by Diane W.

No further discussion; motion carried.

(Note: After discussions with NREMT, AEMTs will be included in the Pilot Project, however, due to technological limitations, they will need to submit their recertification hours on paper.)

Discussion:

- EMT I/85 refreshers will be needed for those maintaining level until sunset date of 2017. This will be accomplished through DEMST policy.
- Continuing education coordinator – Make the same change as listed under EMS Instructor.
- 33-36-01-02 – The recommendation was made to maintain CEC refresher.
- Continuing Education – Will be decided by requirements set by NREMT (NCCR, ICCR, LCCR).
- EMS instructor. ND has an instructor for every 10 EMTs. An instructor needs to teach at the level of producing candidates that can pass the tests.
- Epinephrine is gone.
- Dextrose Administration will remain until Intermediate level is gone.
- EVOC instructor is gone (barring further discussion).

Community Paramedic Update

- Tom has spoken to Ken Reed about contracting as the half-time CP coordinator and is having discussion regarding conflict of interest.
- There are presently 240+ CP programs around the US, many of which utilize local EMS services.
- The national curriculum appears to be light in some areas for ND and may need to be re-visited in the future.
- Ron Lawler (former chair) moved away; the new CP coordinator will serve on the EMSAC subcommittee.
- Tom will bring a formal presentation to the next EMSAC meeting.
- CP Program is known by different names: Mobile Integrated Health Care, Community Health Care EMS.
- Dr Sather commented that MIHC sounds more appropriate as it may not always be EMS personnel.
- Physician champions are needed.
- The plan is to start small and create some successes to build on.
- Another stakeholder meeting is in the works for the near future to define differences between CP and PH and work on the curriculum.

Helmsley Grant

- Amanda submitted the grant application on October 11, 2013.
- This funding is for providing Lucas Mechanical CPR devices to all ground ambulances and hospitals in the state.
- Program totals purchase of 212 devices with number awarded to ambulances based on call volume; critical access hospitals awarded one, tertiary care facilities awarded one for the ED and one for the cath lab.
- The award will be for a whole year, with half the money distributed per half year.
- Devices come with a battery and charging source.
- Due to expense there is no service agreement, but there will be extra machines on inventory to use as loaners as needed for repairs.
- Training is required prior to acceptance of the devices.
- Funding also includes a considerable piece for evaluation totaling \$900,000 for a three-year period.
- Evaluation will look the effect of the device on patient outcome as well as the entire cardiac system of care.

Change of ambulance status to QRU, substation, closure

DEMST will be developing a standard process for requirements when an ambulance / agency closes. This will also include options for changing status to QRU or substation. The process will include a notification process and details of when to

involve the public and/or other entities if they are going to be affected when a plan of action is not followed. The goal is to establish a process to protect the public and maintain proper relations throughout EMS in ND.

Dispatch subcommittee report

Lindsey reported that progress is being made in gaining trust with 911 dispatchers and improving working relations and the right players are involved. Liz Beck shared that each side shares the goal of doing what's best for EMS and finding the right solutions.

- Questions regarding dispatch of QRUs per closest EMS agency law. If QRU isn't in service then delay of care.
- Standards and guidelines committee within 911 Association is working on consistent methodology across the board with PSAPs.
- GIS committee is responsible for coming up with the law, fire and EMS boundaries for next gen 911.

Liz Beck shared information regarding 'FirstNet'. FirstNet is the counterpart to next gen 911 for public safety. Nobody is required to use this network, it is an additional carrier that public safety agencies will have available. There are lots of details yet to be determined. ITD applied for the grant this summer and hired a company to do the development. There are 8 kick-off meetings scheduled with public safety around the state. Anybody is invited to these meetings which will also be available through IVN. There is no need for action by ambulance services at this point. They will be contacted when needed. If anybody is interested in getting involved in the project, it is suggested to get on board early on. 2015 – 2016 is the projected implementation. A presentation has been made to the NDEMSEA board.

Invites coming from FirstNet will include information to be shared. For more questions, the Program Manager's name from ND ITD is Travis Durick, 701-328-1125, tdurick@nd.gov.

Funding area grants overview / update

Applicants were required to submit financial statements this cycle. A variety of formats were received. Due to the amount of requests, awards were capped at \$100,000 and once again there were unallowable categories placed on applications. Diane shared that she didn't feel the application was difficult although it was time consuming.

There was concern over the eligibility and effect of oil counties that were to be eligible for further funding through other sources. DEMST asked for and received an opinion from the Attorney General's office stating that oil counties must be included in the process, but allowing DEMST to alter the funding limited.

Curt asked if the financial statements made scoring easier. Tom felt it almost made it harder as there is such a variance and some small ambulances have a lot of money and it leads back to the question continuously dealt with: 'do we punish those services that are well managed'.

Tom Nehring, Amanda Roehrich and Neil Frame made up the panel of scorers. There was discussion regarding the upcoming cycle. Tom stated that DEMST will begin working on the upcoming cycle soon and bring efforts to the EMSAC for suggestions and review.

Amanda shared the following information regarding the current cycle:

	2013-2014 (current)	2012-2013
Total Number Received	71	76
Total Amount Requested	\$7,802,468	\$7,365,000
Average Amount per Funding Area	\$109,894	\$96,916

Lowest Request	\$14,270	\$5,100
Highest Request	\$312,350	\$347,910
Total Number Funded	69	64
Total Amount Funded	\$3,200,000	\$2,922,295
Lowest Award	\$1,312	\$3,570
Highest Award	\$90,000	\$97,600

The lowest percentage funded was 26.24% because it received the remaining amount. Everyone else was funded from 50% to 90%. No one received 100%.

Still missing 6 Notice of Grant Awards.

Current 2013-2014 Statistics

6 new applicants

- McHenry
- Portal
- Kenmare
- New Town
- Halliday
- Rolla

10 from last year that did not reapply

- Towner County
- Altru
- Southwest Healthcare (Bowman)
- Spirit Lake
- Ryder-Makoti
- Belcourt
- Parshall
- Ambulance Service (Breckenridge)
- Standing Rock
- Carpio/Berthold

New EMS agencies in North Dakota

- Tom has received requests for 2 new ambulance services in Mandari and Alexander.
- These services are in the works with the question of sustainability being explored.

Schedule meetings for 2014

- EMSAC meeting dates will be sent out soon with the following months suggested:
- January
- April
- July
- October

Other Business

SIM ND discussion:

- Diane has had the truck and would use it every month if it was possible
- Ken Reed stated that staff was happy with the training
- Incorrect CPR process was not corrected between scenarios as it should be.
- Feelings that it has been 'after-thought' staffing; therefore if somebody is missing, those available don't know the functionality.
- The intent of the grant was to have committed staff.
- Diane has found it easier to work with them over email.
- Running into bureaucracy with UND in relation to unwillingness to do direct marketing.
- Mona is in the process of becoming a SIM instructor.
- UND is focusing on hospitals rather than reaching out to EMS agencies.
- Simulations are very nurse orientated rather than meeting the needs of EMS personnel.
- Staffing intended to be a 3-person crew: 2 nurses and 1 paramedic or 2 paramedics and 1 nurse.
- Commitment was to have training at every critical access hospital and ambulance service annually.
- Too many students scheduled at once and not allowing time for each person to get hands on time.

Testing question discussion:

- ND approved EMT course taught by a ND and MN licensed instructor finished early before start of college.
- Didn't want to wait to test in October so tested in MN.
- ND is the state to verify results with NREMT if MN will send verification of competency.
- Tim stated that the MN test is structured closer to EMR than EMT.
- Instructor did not notify the state with change of testing plans prior to testing.
- Ken stated that NREMT accepts state testing for basic level all over the country.
- Setting precedence.
- Council advised that it should be considered the instructor's problem rather than the state.

Trauma / clinics

- Lindsey raised a question brought to her from nurse practitioners about trauma patients being brought to clinics by ambulance services in towns with no hospital.
- If patient is in need of an IV and they need assistance, this could be plausible, but not common practice.
- This is not reliable care and could possibly result in delay of care.
- Consider ALS intercept.
- Council advised this is a local issue and the ambulance manager and medical director should be engaged in a discussion.

Adjourn